

# Criteria Based Consultation Prescribing Program

## CRITERIA FOR DRUG COVERAGE

### roflumilast (Daliresp<sup>®</sup>) tablet

Non-formulary **roflumilast (Daliresp<sup>®</sup>)** gel will be covered on the prescription drug benefit when the following criteria are met:

- Prescribed by a Pulmonology or Allergy specialist
  - AND -
- Diagnosis of COPD associated with chronic bronchitis\*
  - AND -
- Post-bronchodilator FEV1 less than 50% or FEV1/FVC less than 0.7
  - AND -
- Two or more acute exacerbations requiring treatment with systemic corticosteroids in the past 12 months - **OR** -  
an acute COPD exacerbation requiring hospitalization in the past 12 months
  - AND -
- Treatment optimized with inhaled anticholinergic, long acting beta-agonist, and inhaled corticosteroid
  - AND -
- BMI is at least 18.5
  - AND -
- No diagnosis of depression on problem list AND depression screen negative
  - AND -
- No significant liver disease
  - AND -
- No active diarrheal disease

\*Chronic bronchitis = presence of daily cough with sputum production for at least 3 months of the year in each of 2 consecutive years.